



Guidance for Non-HIV-Specialized Providers Caring for HIV-Infected Residents Displaced from Disaster Areas

Downloaded from <https://aidsinfo.nih.gov/guidelines> on 8/31/2017

Visit the *AIDSinfo* website to access the most up-to-date guideline.

Register for e-mail notification of guideline updates at <https://aidsinfo.nih.gov/e-news>.

Guidance for Non-HIV-Specialized Providers Caring for HIV-Infected Residents Displaced from Disaster Areas

*Essential Information for Managing HIV-Infected
Patients Receiving Antiretroviral Therapy*

August 26, 2011

Prepared by:

HHS Panel on Antiretroviral Guidelines for Adults and Adolescents

HHS Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission

HHS Panel on Antiretroviral Therapy and Medical Management of HIV-Infected Children

HHS Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults & Adolescents

HHS Panel on Guidelines for the Prevention and Treatment of Opportunistic Infection in HIV-Infected Children

For more detailed information regarding treatment and care for the HIV infected patient, consult the following website: <http://aidsinfo.nih.gov/Guidelines/Default.aspx>

Guidance for Non-HIV-Specialized Providers Caring for HIV-Infected Residents Displaced from Disaster Areas

The following information provides guidance to health care providers attending to the medical needs of HIV-infected adults (including pregnant women) or children displaced from disaster areas who have not yet secured HIV care in the areas where they have relocated.

Management of antiretroviral therapy is complex and, if possible, should be done with the assistance of clinicians with experience in HIV care. Medical consultation may also be available at specific local or regional HIV clinics. After the initial assessment of a patient's immediate medical needs, if at all possible, the patient should be referred to the care of an HIV clinician in the area.

INITIAL ASSESSMENT

1. Assess the patient's general health and need for immediate medical intervention. Acute illnesses should be diagnosed and attended to promptly.
2. Obtain the following information from the patient:
 - a. Name, location, phone number, pager number, and e-mail address of the primary HIV care provider/clinic and research staff (if the patient is participating in a research study such as a clinical trial).
 - b. The name, location, and phone number of the pharmacy where the patient obtained medications.
 - c. Pertinent past medical history (including history of opportunistic infections [OIs] or malignancies and other medical conditions such as hypertension, diabetes mellitus).
 - d. Latest known CD4 cell count/percentage and viral load and approximate date when they were obtained.
 - e. Current medications including:
 - i. antiretroviral drugs* (most recent/current drugs and drugs used in the past, if available)
 - ii. Any investigational medication (if the patient is participating in a clinical trial, obtain information about the clinical trial site and contact information, if available)
 - iii. medications for treatment of OIs
 - iv. medications for prevention of OIs
 - v. other medications
 - f. Brief family history including any HIV-infected children or other family members.

* Note: Using pamphlets or booklets with images of antiretroviral drugs and other medications may help patients to recall or identify their medications. The images of Food and Drug Administration (FDA)-approved antiretroviral medications can be found at http://aidsinfo.nih.gov/contentfiles/HIV_Pill_Poster.pdf

- g. History of drug allergy and type of reactions—especially ask if there is any history of serious reactions to antiretroviral medications or drugs used for treatment or prevention of OIs, such as trimethoprim-sulfamethoxazole. Patients who have had positive genetic tests for the HLA-B*5701 allele should not be given abacavir or fixed-dose combinations containing abacavir because HLA-B*5701 predisposes patients to life-threatening hypersensitivity reactions.
- h. History of intolerance to antiretroviral medications and other medications.
- i. Vaccination history (may be obtainable from local/regional/state registries).

GENERAL MEDICATION MANAGEMENT STRATEGIES

Patients who had their antiretroviral therapy and/or prophylaxis or treatment for OIs interrupted by disaster-related displacement should restart these medications as soon as possible. There is no need to start antiretroviral therapy immediately in those HIV-infected patients who were not receiving antiretroviral medications before the disaster. In these patients, initiation of therapy can be delayed until a more thorough assessment can be made; if necessary, patients should be referred to a local HIV specialist for further medical care.

1. Antiretroviral Therapy Management

- a. All antiretroviral drugs should be restarted at the same time. If the patient was receiving nevirapine (Viramune) as part of a regimen and has not taken nevirapine for more than 7 days, it should be restarted with a 2-week “lead-in” period, giving half the daily dose once daily for 14 days and then standard twice-daily dosing.
- b. In general, the patient should be on a combination regimen consisting of a total of at least three different antiretroviral drugs.
- c. Note that some antiretroviral drugs are available in fixed-dose formulations where two or more drugs are combined into one pill (e.g., Atripla[®] = efavirenz + emtricitabine + tenofovir; Combivir[®] = zidovudine + lamivudine; Complera[®] = rilpivirine + tenofovir + emtricitabine; Epzicom[®] = abacavir + lamivudine; and Truvada[®] = emtricitabine + tenofovir).
- d. Pediatric patients may be taking liquid formulations, some of which may need to be refrigerated. Special attention should be paid to appropriate weight- or surface area-based dosing for pediatric patients.
- e. If patients cannot recall drug dosages or cannot recall their regimens, consult an HIV care specialist or consultation service for recommendations or contact the pharmacy where they most recently obtained their medications.
- f. Patients with a history of the following serious reactions to the following agents should not be rechallenged with the same drugs:
 - i. Symptomatic hepatitis or Stevens-Johnson syndrome from nevirapine (Viramune[®] or Viramune XR[®])

- ii. Hypersensitivity reaction from abacavir (Epzicom[®], Ziagen[®], or Trizivir[®])
 - iii. Pancreatitis from didanosine (Videx[®] or Videx EC[®])
 - iv. Serious rash with any antiretroviral medication
- g. Antiretroviral medications may interact with each other and with many other drugs. Please consult product labels, an HIV care specialist, or a pharmacist when concerned about drug-drug interactions. Tables with common antiretroviral drug interactions can also be found in the latest adult and pediatric antiretroviral guidelines as well as guidelines for treatment of pregnant women and prevention of mother-to-child transmission of HIV at <http://aidsinfo.nih.gov/guidelines>.
- h. The above guidelines also include information regarding dosing and adverse effects of antiretroviral drugs as well as special considerations in certain patient populations, such as patients coinfecting with hepatitis B, hepatitis C, and tuberculosis.

2. *Caring for the HIV-Infected Pregnant Women*

- a. All HIV-infected pregnant women should be entered into standard prenatal/obstetric care as soon as possible.
- b. **The National Perinatal HIV Hotline service provides clinicians with 24 hour consultations with experts on treating HIV-infected pregnant women and HIV-exposed infants: 888-448-8765.** The hotline also serves as a clinicians' network and can assist providers with identifying clinicians nationwide who have experience in the management of HIV-infected pregnant women and HIV-exposed infants.
- c. HIV-infected pregnant women who discontinued antiretroviral drugs used for treatment or prevention of mother-to-child transmission of HIV during displacement should urgently restart therapy.
- d. Pregnant women in the first trimester should not receive efavirenz (in Sustiva[®] or Atripla[®]) because of potential teratogenicity.
- e. All HIV-infected pregnant women who are in the second or third trimester should be receiving antiretroviral therapy regardless of their CD4 count. In general, three antiretroviral drugs are used for prevention of mother-to-child transmission.
- f. Pregnant women with CD4 counts >250 cells/mm³ should not be started on nevirapine (Viramune[®]) as part of the new regimen because of the risk of serious liver toxicities.
- g. Elective cesarean delivery is recommended for HIV-infected pregnant women who have HIV RNA $>1,000$ copies/mL in the late third trimester (i.e., >36 weeks' gestation), regardless of whether they are receiving antiretroviral drugs (see perinatal guidelines, Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health *and* Interventions to Reduce Perinatal HIV Transmission in the United States for dosing, available at: <http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf>).

- h. HIV-infected women in labor should receive their typical oral antiretroviral regimen plus intravenous zidovudine (abbreviated as AZT or ZDV). (For dosing, see Table 7 in perinatal guidelines, available at: <http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf>.) Infants should receive ZDV prophylaxis for 6 weeks (Table 7 of the perinatal guidelines). Recommendations on infant prophylaxis for special situations (e.g., when the mother has not received any antepartum antiretroviral drugs) where additional infant drugs may be administered are available in the perinatal guidelines at <http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf>.
- i. HIV-infected women in the United States should not breastfeed their infants.
- j. Treatment and prophylaxis for OIs should also be restarted. A section on “Special Consideration during Pregnancy” is available under each OI in the most current guidelines for treatment and prevention of OIs (<http://aidsinfo.nih.gov>).
- k. As soon as possible, HIV-infected pregnant women should be referred to specialists with expertise in managing these patients for obstetric as well as HIV management.

For more comprehensive information regarding antiretroviral therapy, please go to <http://aidsinfo.nih.gov/guidelines/>.

3. Prophylaxis for Opportunistic Infections

OI prophylaxis that had been interrupted should be continued as soon as possible. For more detailed information and recommendations regarding prevention and treatment of OIs in adult and pediatric patients, please refer to the guidelines at <http://aidsinfo.nih.gov/guidelines/>.

Indication	OI	Prophylaxis regimen
<p>Adults, adolescents, and children >6 years of age: Latest known CD4 count <200 cells/mm³ or CD4 percentage <14% or history of <i>Pneumocystis jirovecii</i> pneumonia (PCP)</p> <p>Children 1–5 years of age: Latest known CD4 count <500 cells/mm³ or CD4 percentage <15%</p> <p>Children <12 months of age:</p> <ol style="list-style-type: none"> All infants born to women with HIV infection starting at age 4–6 weeks, after completion of the zidovudine prophylaxis regimen, unless there is adequate test information to presumptively exclude HIV infection All HIV-infected infants <12 months of age. 	Prophylaxis against <i>Pneumocystis jirovecii</i> pneumonia (PCP)	<p><u>1st Line:</u> trimethoprim-sulfamethoxazole</p> <p><u>Alternatives:</u> dapsone or atovaquone or monthly inhaled pentamidine</p>
<p>Adults, adolescents, and children >6 years of age: Latest known CD4 count <50 cells/mm³</p> <p>Children 1–2 years of age: Latest known CD4 count <500 cells/mm³</p>	Prophylaxis against disseminated <i>Mycobacterium avium</i> complex infection	Azithromycin

Children <1 year of age: Latest known CD4 count <750 cells/mm ³		
--	--	--

4. Vaccinations

General Recommendations:

- a. Practitioners should refer to the Centers for Disease Control and Prevention (CDC) Web site (<http://emergency.cdc.gov/disasters/alldisasters.asp> and <http://emergency.cdc.gov/disasters/disease/facts.asp>) for updated general recommendations for individuals displaced by disasters.
- b. Inactivated influenza vaccine is recommended for all HIV-infected patients (adult or pediatric and including pregnant women). This is especially important as the residents continue to reside in large crowded areas.
- c. All patients who received immunization at temporary medical care facilities should be given written documentation of the date and types of such immunization as records for their primary HIV care providers. If available, immunization administration can be submitted to a local/area immunization registry.

Specific Recommendations for Adult HIV Patients:

- a. Adult formulation of **Tetanus/diphtheria toxoids/acellular pertussis (Tdap)** should be given to adult (including pregnant women) and adolescent patients with HIV if it has been at least 10 years since last vaccination or vaccination date unknown.

Specific Recommendations for Pediatric HIV Patients:

HIV-infected children should adhere to the routine childhood immunization schedule (<http://www.cdc.gov/nip/recs/child-schedule.html>). (The complete recommendations on immunization for HIV-infected children can be found in the Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Exposed and Infected children, available at: <http://aidsinfo.nih.gov>.)

More information regarding antiretroviral management in adult, pregnant, and pediatric patients as well as recommendations for prophylaxis and treatment of specific OIs can be found at <http://aidsinfo.nih.gov/guidelines/>.